SIXSMITH DECLARATION

EXHIBIT A

New York Hospital Queens

56 Main Street, Flushing, NY 11355 / Tel. 718-670-1426 / Fax. 718-661-7746

Department of Emergency Medicine

February 26, 2008

Jose L. Velez, Esq.
Assistant Attorney General
New York Sate Department of Law
Litigation Bureau—24th Floor
120 Broadway
New York, NY 10271

Re: Estate of Valerie Young by Viola Young, Administratrix, et al, v. State of New York Office of Mental Retardation and Developmental Disabilities, et al

Dear Mr. Velez:

At your request, I have reviewed the following material in the above matter in order to formulate my opinion on the medical care given to Valerie Young:

Summons;
Investigation of Consumer Death, stamped "Young 11/07", pages 0001 to 0241;
Medical records, 2004-2005, stamped "Young", pages 7628 to 8797;
"Minor Occurrence" forms, 11/30/04; 12/1/04; 12/10/04; 12/21/04; 12/23/04; 12/24/04; 1/2/05; 1/9/05; 1/18/05; 1/25/05; 1/27/05; 2/11/05; 3/10/05; 3/14/05; 3/17/05; 3/22/05; 3/28/05; 4/7/05; 5/4/05.

Valerie Young was a 49 year old woman who had resided at the Brooklyn Developmental Center since 1990. She had a history of profound mental retardation, seizure disorder, schizoaffective disorder, tardive dyskinesia, constipation, right brachial plexopathy, and left foot drop due to mononeuropathy. She had a hemorrhoidectomy in 1998 and a fractured right index finger in 2002. She had a normal echocardiogram and a negative venous duplex ultrasound in 2001. She had frequent episodes of agitation, aggressive behavior and behavioral decompensation requiring psychiatric hospitalization and/or adjustment of her psychotropic medications. Her medications at the time of her death were Inderal, Klonopin, Topomax, Prevacid, Remeron, Vitamin B, Zyprexa, Tegretol, Colace, Metamucil, and Fleet's enema.

In March of 2005, Ms. Young was noted to have worsening of her gait problems and increasing falls. In April, 2005, she had an extensive annual physical and psychiatric evaluation that included neurological consultation, x-rays of the lumbar spine, and

physical therapy evaluation. X-rays of her lumbar spine were negative. An EMG was scheduled for 6/3/05 to evaluate her gait disturbance and foot drop.

Because of frequent falls, her medication regimen was adjusted with reduction in her Zyprexa dose. After a fall that caused a laceration of her scalp on 5/20/05, a wheelchair was used for "all mobility needs" although she continued to have physical therapy and was ambulated with assistance. On 5/27/05, she was noted to have bilateral ankle edema (swelling) but had no calf tenderness and a negative Homann's sign (a physical examination test for deep vein thrombosis). Her edema was assumed to be positional, (i.e., her legs in a prolonged dependent position) and leg elevation during rest periods was recommended.

On 6/19/05 Ms. Young collapsed in the shower. Resuscitative efforts were instituted by the staff including CPR, intravenous dextrose, and oxygen. After CPR, she again became responsive and was agitated. On the arrival of the paramedics, Ms. Young was given intravenous atropine and was intubated for ventilatory support. She was transported to the hospital where she was pronounced dead shortly thereafter. At autopsy she was found to have bilateral pulmonary embolism and bilateral deep vein thrombosis.

In my opinion, the oversight, monitoring, evaluation, and treatment of Ms. Young was thorough and according to the accepted standard of care. When it was noted she was not only having increasing gait disturbance but increasing frequency of falls in April, 2005, she was referred for further evaluation, and the appropriate restrictions were placed on her activities to prevent further injury. When her ankle edema was noted on 5/27/05, her physician made the completely reasonable diagnosis of positional or dependent edema. That diagnosis was reasonable for at least three reasons—previous evaluation of her edema had been negative for deep vein thrombosis in 2001 when she had a negative venous duplex ultrasound; her examination was non-diagnostic for deep vein thrombosis in that her legs were non-tender; and her edema was bilateral. Typical physical findings in deep vein thrombosis are unilateral edema, calf tenderness, and/or pain on ambulation, none which she had. Recognizing that her edema may have been aggravated by her periodic confinement to a wheelchair, her physician recommended leg elevation, which is the usual treatment for dependent edema.

It is further my opinion that her care providers could not have reasonably anticipated that Ms. Young would develop bilateral deep vein thrombosis and fatal pulmonary embolism. Ms. Young had none of the currently accepted risk factors or symptoms that are recognized to increase the likelihood of a diagnosis of deep vein thrombosis, which are: active cancer; recently bedridden for major surgery; unilateral calf or leg edema; paralysis or a leg cast in the recent past; localized calf tenderness; collateral superficial veins. And the fact that she continued to receive physical therapy, continued to ambulate with assistance at her facility, and appeared to remain completely asymptomatic for the next three weeks until her death would have reinforced the impression that she was not at risk for any serious condition.

At the time of Ms. Young's collapse on 6/19/05, immediate and appropriate measures were taken to provide emergency care and resuscitation. According to the records there was prompt recognition of her agonal state and notification and rapid response of the nurse and physician on site. In fact, although Ms. Young initially was observed to be not breathing and without a pulse, the resuscitative measures instituted by the staff were sufficient to revive her to the point of responsiveness and agitation until EMS arrived to take over her care.

Therefore, in summary, it is my opinion that Ms. Young was treated according to the accepted standard of care both prior to and at the time of her collapse on 6/19/05. I have formulated these opinions based on the following qualifications: my board certifications in internal medicine and emergency medicine; my experience as a clinician for more than 30 years treating many patients with both deep vein thrombosis and pulmonary embolism; my experience as a teacher of medical students and resident physicians in various specialties on the presentation and treatment of deep vein thrombosis and pulmonary embolism; and my experience in the last few years treating many patients with developmental disabilities in the Emergency Department at New York Hospital Queens, which is a major referral source for care for a local center for patients with developmental disabilities.

That latter experience has demonstrated to me that the treatment of these patients is challenging and complex. As they are often unable to articulate their needs, precisely describe their symptoms, or cooperate with examination and testing, it requires both patience and attention to the smallest nuances of behavior to make an accurate diagnosis. While I did not personally observe the care administered to Ms Young, a review of her medical records demonstrates an ongoing process of attention to Ms. Young's needs and well-being.. From ensuring that she had good tooth brushing to providing stimulation during activity periods to dealing with and addressing her aggressive behavior without over-sedating her, there is evidence of ongoing monitoring and follow-up to ensure that care plans were carried out and symptoms were expeditiously addressed.

I am being compensated for my time at the rate of $350/hour for record review and report preparation. Attached to this report is a current copy of my curriculum vitae listing my qualifications and my publications. Also attached is a list of cases in which I have served as a medical expert and in which I have been deposed or testified in the preceding four years.

Sincerely,

Diane M. Sixsmith, M.D., M.P.H., FACEP

CURRICULUM VITAE

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Department of Emergency Medicine
New York Hospital Queens
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Flushing, New York 11355

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EDUCATION:

Trinity College, Washington, D.C., B.A., Cum Laude, 1969
Major Field: English Literature; Minor Fields: Chemistry, Biology, Theology

University of Pittsburgh School of Medicine, Pittsburgh, PA.
M.D., 1973

Columbia University School of Public Health, New York, New York
M.P.H. in Health Administration, 1977

PROFESSIONAL TRAINING:

Internship, Straight Medicine, Harlem Hospital Center,
in Affiliation with the College of Physicians and Surgeons, New York, New York
July 1, 1973 - June 30, 1974

Residency, Internal Medicine, Harlem Hospital Center
July 1, 1974 - June 30, 1976

ACADEMIC APPOINTMENTS:

1994 – Present Assistant Professor of Emergency Medicine in Clinical Medicine, Weill Medical College of Cornell University

1994 - 2001 Co-Chief, Div ision of Emergency Medicine, Departments of Medicine and Surgery

1992 - 1994 Assistant Clinical Professor in Medicine, New York University School of Medicine and Bellevue Hospital Center

1989 - 1992 Instructor in Medicine, New York University School of Medicine and Bellevue Hospital Center

1987 - Present Adjunct Professor, Department of Allied Health, Borough of Manhattan Community College, City University of New York; Medical Director, Paramedic Training

1976 - 1980 Instructor in Clinical Medicine, Department of Medicine, Columbia University College of Physicians & Surgeons,

1976 - 1982 Faculty, Emergency Medicine, Physicians Assistant Program, Harlem Hospital Center & the Sophie Davis School of Biomedical Education of the City University of New York

HOSPITAL APPOINTMENTS:

1992 - Present
Chairman, Department of Emergency Medicine, New York Hospital Medical Center of Queens (formerly Booth Memorial Medical Center), Flushing, New York

1997 - 1999
Director, Department of Emergency Medicine, New York Flushing Hospital, Flushing, New York

1992 – 1998
Attending Physician, Emergency Department, Hudson Valley Hospital Center, Peekskill, NY

1980 - 1992
Medical Director, Emergency Department, New York Downtown Hospital (formerly New York Infirmary-Beekman Downtown Hospital), New York, New York

1980 - 1993
Attending Physician, Department of Medicine, New York Downtown Hospital

1977 - 1980
Chief of Emergency Services, Harlem Hospital Center, New York, New York

1976 - 1979
Staff Physician, Rikers Island Health Services, Montefiore Hospital and Medical Center, New York City

AWARDS AND HONORS:

Fellow, American College of Emergency Physicians, awarded 1989

OTHER PROFESSIONAL POSITIONS:

Reviewer, Academic Emergency Medicine, 1999-present

Member, Board of Professional Medical Conduct, New York State Department of Health, 2004-present

Consultant, Research Triangle Institute, Center for the Study of Social Behavior, Research Triangle Park, N.C., Medical Costs of Drug Abuse, 1977 - 1980

Consultant, New York County Health Services Review Organization.
1977 - 1984

LICENSE AND CERTIFICATIONS:

New York State License - 122203 issued July, 1974
DEA - AS6300723
Diplomate, American Board of Emergency Medicine, October, 1986; Recertified, December, 1996; November, 2006
Diplomate, American Board of Internal Medicine, June 1976
Diplomate, National Board of Medical Examiners, March 1974
Licensed Physician, New York State, Registration No. 122203
Certified Basic & Advanced Cardiac Life Support Instructor
Certified Advanced Trauma Life Support Instructor
Certified Pediatric Advanced Life Support Instructor

COMMITTEE MEMBERSHIPS:

Chairman of the Medical Board, 2003-2004; Vice Chairman of the Medical Board, 1996—2002; Secretary of the Medical Board, 1994-1996; New York Hospital Medical Center of Queens

Member, Board of Trustees, New York Hospital Medical Center of Queens, 1998—2004

Member, Board of Directors, Heritage Affiliate (New York City, Long Island, New Jersey, Connecticut), American Heart Association, 1999—2004

Member, Board of Directors, National Marfan Foundation, 2004—present

Member, Board of Directors, New York Heart Association, 1984 - 1990;
1992 - 1999

1987 - Present Adjunct Professor, Department of Allied Health, Borough of Manhattan Community College, City University of New York; Medical Director, Paramedic Training

1976 - 1980 Instructor in Clinical Medicine, Department of Medicine, Columbia University College of Physicians & Surgeons,

1976 - 1982 Faculty, Emergency Medicine, Physicians Assistant Program, Harlem Hospital Center & the Sophie Davis School of Biomedical Education of the City University of New York

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1997 - 1999
Director, Department of Emergency Medicine, New York Flushing Hospital, Flushing, New York

1992 – 1998
Attending Physician, Emergency Department, Hudson Valley Hospital Center, Peekskill, NY

1980 - 1992
Medical Director, Emergency Department, New York Downtown Hospital (formerly New York Infirmary-Beekman Downtown Hospital), New York, New York

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Attending Physician, Department of Medicine, New York Downtown Hospital

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Consultant, Research Triangle Institute, Center for the Study of Social Behavior, Research Triangle Park, N.C., Medical Costs of Drug Abuse, 1977 - 1980

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Member, Board of Trustees, New York Hospital Medical Center of Queens, 1998—2004

Member, Board of Directors, Heritage Affiliate (New York City, Long Island, New Jersey, Connecticut), American Heart Association, 1999—2004

Member, Board of Directors, National Marfan Foundation, 2004—present

Member, Board of Directors, New York Heart Association, 1984 - 1990;
1992 - 1999

President, American Heart Association, New York City Affiliate, 1997-1999; President-Elect, 1995-1997

Member, Board of Directors, New York Chapter, American College of Emergency Physicians, 1991 - 1994

Member, Advisory Council, Emergency Medicine Section, New York Academy of Medicine, 1993 - Present

Woman Liaison Officer, Women in Academic Medicine, Association of American Colleges, 1994 - 2000

Chairman, Practice Management Committee, New York Chapter
American College of Emergency Physicians, 1990 - 1992

Chairman, Council on Community Programs, New York Heart Association 1989 - 1993

Chairman, Resource Council, New York Heart Association, 1993 - 1997

National Faculty, ACLS and BCLS, American Heart Association,
1984 - 1990

Chairman, New York Heart Association Subcommittee on Hospital Training, 1982 - 1987

Chairman, New York Heart Association Emergency Cardiac Care Committee, 1987 - 1989, Member 1981 - 1989

Member, N.Y.C. Regional Emergency Medical Services Council 1982 - 1989

Chairman, Regional Emergency Medical Services Council
1984 - 1988

Member, N.Y.C. E.M.S. Advanced Life Support Committee 1978 - Present

Member, New York City EMS Committee on General Emergency Department Standards, 1977 - 1984

Chairman, New York City Medical Advisory Committee Subcommittee on Paramedic Training & Testing - 1980 - 1983

Consultant, New York State Department of Substance Abuse Services
Task Force on PCP, 1979 - 1981

PROFESSIONAL SOCIETIES:

Member, Society for Academic Emergency Medicine, 1993 - Present
Member, American College of Emergency Physicians, 1986 - Present
Member, American College of Physicians, 1990 - 1994
Member, American Women's Medical Association, 1986 - 2000

BIBLIOGRAPHY

Peer Review Journals:

Sixsmith, D., "Case Studies in Acute Aortic Dissection: Strategies to Avoid a Catastrophic Outcome," ASHRM Journal. 2005, Vol. 25, No.2:15-18.

Cregin, R., Segal-Maurer, S., Weinbaum, F., Rahal, J., Karbowitz, S., Sixsmith, D., Cassata, V., Danek, M., Battelman, D., Callahan, M., "Multidisciplinary Approach to Improving Treatment of Community Acquired Pneumonia," American Journal of Health-System Pharmacy. February 15, 2002, Vol. 59, No. 4:364-68.

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Sixsmith, D., Weissman, L, & Constant, F, "Telephone Follow-up for Case Finding of Domestic Violence in an Emergency Department," Academic Emergency Medicine, April, 1997, Vol. 4, No. 4: 301-304.

Weinbaum, F., Lavie, S., Danek, M., Sixsmith, D., Heinrich G., & Mills, S., "Doing It Right the First Time: Quality Improvement and the Contaminant Blood Culture," Journal of Clinical Microbiology, March, 1997, V. 35, No. 3: 563-565.

Shields, C. & Sixsmith, D., "Treatment of Moderate to Severe Hypothermia in an Urban Setting," Annals of Emergency Medicine,
October, 1990, V. 19, No. 10:1093--1097.

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Sixsmith, D. & Goldman, F., "The Medical cost of Drug Abuse in an Inner-City Community, American Journal of Public Health, May 1979, Vol 69, No. 5:505-7.

Abstracts

Chen, P., Sixsmith, D., "Early Treatment Unit Does Not Improve Hospital Length of Stay for ED Boarders," Academic Emergency Medicine, May, 2007, Vol 14, No. 5, Supp 1, S54.

Shuchat, S., Sixsmith, D., Hei Shun Yu, "Perception of Language as a Barrier to Care among Non-English Speaking Patients," Academic Emergency Medicine, May, 2007, Vol 14, No. 5, Supp 1, S201.
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Sixsmith, D., Weinbaum, F., Chan, S., Nussbaum, M., Magdich, K., "Reduction of Hemolysis of Blood Specimens Drawn from ED Patients for Routine Chemistry Tests by Use of Low Vacuum Collection Tubes," Academic Emergency Medicine, May, 2000, Vol 7, No.5:525.

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Book Chapters

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Sixsmith, D., & Rehm, C., "Accidents and Emergencies," in The Women's Complete Healthbook, Edited by Epps, R., and Stewart, S., Delacorte Press, 1995.

Sixsmith, D., "Food Poisoning," House Calls, edited by Couzens, G., Simon and Schuster, New York, 1993.

INVITED LECTURES

Medical Liability Mutual Insurance Company Annual Risk Management Seminar, "Top Five Risk Management Issues in Your ED," New York, NY, November 4, 2005.

Risk Management and Patient Safety Institute, "High Risk Areas in Emergency Medicine," Minnesota and North Dakota, September 13-17, 2004.

Risk Management and Patient Safety Institute, "Emergency Medicine: Focusing on High Risk Areas", Audio Conference, 7/21/2004.

Marfan Syndrome Symposium, "Emergency Management of Aortic Dissection, Cedars-Sinai Medical Center, Los Angeles, CA, 7/9/2004.

Philadelphia Area Society for Healthcare Risk Management, "Top Five Conditions Leading to ER Malpractice Claims", Plymouth Meeting, PA., 5/20/2004.

Risk Management and Patient Safety Institute, "High Risk Conditions Leading to Emergency Room Malpractice Claims," St. Joseph, MI., 3/30-31/2004.

Risk and Quality Conference, Providence Health System, "How to Make the ED Safer," Seattle, WA., 3/25/2004.

American Society for Healthcare Risk Management, "Top Five Conditions Leading to Emergency Room Malpractice Claims," Nashville, TN, 11/2-3/2003.

Lincoln Hospital and Mental Health Center, Emergency Medicine Residency Program Grand Rounds, " "Acute Aortic Dissection—Diagnosis and Management", Bronx, NY, 6/4/2003.

Lincoln Hospital and Mental Health Center, Emergency Medicine Residency Program Grand Rounds, "Ethics in Emergency Medicine", Bronx, NY, 11/20/2002

Stamford Hospital Department of Medicine Grand Rounds, "Acute Aortic Dissection—Diagnosis and Management", Stamford, CT., 7/10/2002.

New York Chapter, American College of Emergency Physicians, Annual Scientific Assembly, "Gyn Emergencies" and "Trauma in Pregnancy", Lake George, NY, 7/8/2002.

American Heart Association Conference on Marfan's Disease, New York Academy of Medicine, "Acute Aortic Dissection—Diagnosis and Management", New York, NY, 5/1/2002.

FUNDED RESEARCH

Co-Principal Investigator, HEW Grant No. 1R01DA00-86-02A
Grant Received March, 1979, National Institute on Drug Abuse, "Improved Reporting Methods for Detecting Utilization of Health Resources Because of Complications of Drug Abuse"

Revised 10/12/07

Expert Witness Trial and Deposition Testimony, 2003--2008
Diane Sixsmith, M.D.

Armitage, Carl (Kreisman-Medical Legal Evaluation)—**Deposition, NJ, 10/27/06**
Babb, Crystal (Gary Wais)—**Deposition, Maryland, 6/20/07.**
Bartholomew, Emily (Kennedy, Johnson)—**Deposition, CT., 9/15/06**
Beattie, Allan (Jacques)-**Deposition, CT., 2/6/03, Trial, CT, 10/8/03**
Blumenthal v Augustin (Pilkington & Leggett)-**Trial, Monticello, NY, 1/17/03,**
Bovell (Andel) **Deposition, New Jersey, October 23, 2001, Trial, Passaic County, 1/14/04**
Brooks, Gerrod (Gary Wais)—**Deposition, 7/1/03, Maryland**
Bueno v. Keefer (Peltz & Walker)-**Trial, New York County, 1/16/03**
Carson, Barbara v. Janicke (Paul Beltz)—**Trial, Buffalo, NY, 5/2/07**
Choi, Samuel (Blume,Goldfaden)—**Deposition, March 21, 2003, May 20, 2003,**
Curzi, Dewey v. Warren Hospital (Arthur J. Russo) **Deposition, October 29, 2004, Phillipsburg, NJ**
Davis, Rodney (State of NY—Criminal)—**Trial, April 30, 2007, NY Cty**
DeJesus, Ruby (Littlepage)-**Deposition, Maryland, 4/19/06**
Doorandish (Hillman Brown)-**Trial, Annapolis, MD., 2/11/03, Closed**
Fuller-Baker, Kenyon (Meisrow & Stravitz)—**Deposition, MD, 8/10/04**
Gardner, Linda (Richard Lenter)-**Deposition, 9/11/06 (Michigan)**
Giangeruso, Michael (Eichen, Levinson)-**Deposition (NJ)—8/22/06**
Gibbs, Eugenia v. Kovachs, et al (Kline & Specter)—**Deposition, NJ, 11/18/05**
Hammons,Susan (Peter Ervin)-**Deposition, Louisville, KY, 5/12/06**
Harris v. South Nassau (Bartlett)—**Trial, Nassau County, 8/16/04**
Harris, John (Kolsby Gordon)—**Trial, Philadelphia, 6/27/06**
Holcomb, Charles (Andel)—**Trial, Philadelphia, April 14, 2003**
Jacoby, Toby (Harry I. Kate)—**Trial, Nassau Cty, 10/7/05**
Jett, Christa (Blume,Goldfaden)—**Deposition, NJ, 4/2/03**
Jones, Jeffrey (Cardaro & Peek)—**Deposition, 10/20/06, Baltimore, Maryland**
Jones, Linda (Littlepage)—**Deposition, 9/30/05, Maryland**
Kresky, Lawrence (Andel-Colleran)—**Deposition, Pa, 4/16/04**
Lahtinen v. Allyne (Pilkington & Leggett)—**Trial, Orange County, NY, 9/18/03**
LaSalle, Joe (Eshelman Legal Group)-**Trial, Akron,OH, 3/2/06**
Lanza v. Westchester County Medical Center **Trial, White Plains, July 15, 2004**
Loyd, Dorothy v. Cass Medical Center (Dempsey & Kingsland)—**Deposition, 10/24/06, Jackson Cty, Missouri, Trial, Jackson Cty, 4/17-18/07**
Massey, Norma (Andel)-**Deposition, 11/02/05 North Carolina**
Mathews, Lori (Andel-Kline)—**Deposition, May 14, 2004**
McKeever vs. Pollizzi (Wingate)-**Trial, 2/16/06, Bronx**
McKenstry v. UMMSC, et al (Snyder, Weltchek) **Deposition, Baltimore, MD, 12/7/07**
Miller v. Madell and the Cornwall Hospital (Tancredi)—**Trial, Goshen, NY, 12/8/2003**
Moyer, Scott v. Aultman Hospital (Harrington, Schweers)-**Deposition, Ohio,**

4/25/06
Olszyk, Christine (Blume, Goldfaden)**-Deposition, NJ, 3/2/07**
Pauling, Isaiah (Ferraro & Zugibe)**—Trial, 4/26 and 4/28/05, Rockland County, NY**
Placek v. Community Medical Center (Blume, Goldfaden)**—Deposition, Ocean Cty, NJ, 2/26/08**
Pepe, Samantha (Kennedy Johnson)**—Deposition, CT, 3/9/07**
Polis (Andel)**—Trial, Doylestown, Pa, (Bucks Cty), 5/25/04**
Rosado, Gina v. Montefiore (Wilson)**—Trial, Bronx, 2/3/06**
Schoch, Kaitlyn (Blume,Goldfaden)**-Deposition, NJ, 5/5/06**
Spiro, Marilyn (Weiner & Weltchek)**—Deposition, MD—9/22/05. Trial, Montgomery County, Md., 5/16/06**
Suschenko v. Dyker Emergency Physicians (vonSalis)**—Trial, Kings Cty, 10/12 and 10/14/ 2004**
Thompson, Stevie (Kline and Specter)**—Deposition, NJ, 4/15/04**
Watkins, Tamara (Ward & Caggiano)**-Deposition, Orlando, Fl—Brevard Cty), 10/18/06**
Wetzel, Timothy, Estate of (Meub Associates)**—Deposition, Grand Rapids, Michigan, December 12, 2003**
Winfree, Daryl (Landers)**—Trial, March 2006, Queens Cty**

SIXSMITH DECLARATION

EXHIBIT B

The Pottsville Hospital and Warne Clinic

Celebrating 110 years
1895 - 2005

April 25, 2008

Jonathan Bauer
Attorney at Law
134 East 93rd Street
Apt. 11A
New York, NY 10128

Re: Case of Valerie Young

Dear Attorney Bauer:

At your request I have reviewed and evaluated documents regarding the death of Valerie Young to formulate an opinion based on reasonable medical certainty on the causation of death of Valerie Young who expired at the age of 49 years on June 19, 2005.

I have reviewed the following documents to arrive at my opinion:

1. Letter by Mark Rappaport, RN, of the State of New York Commission on Quality of Care and Advocacy for Persons with Disabilities dated October 24, 2005 addressed to Peter Uschakow, Director, Brooklyn DDSO

2. A letter by Diane M. Sixsmith, M.D. dated February 26, 2008 addressed to Jose L. Velez, Esq., Assistant Attorney General, New York State Department of Law.

3. Case analysis report of Investigator Mark Rappaport.

4. Selective medical records of Valerie Young from Brooklyn Development Center

2. The report of the autopsy performed on the body of Valerie Young on June 20, 2005 by Frede I. Frederic, M.D. in the Brooklyn Mortuary of the Office of Chief Medical Examiner of the City of New York.

I offer the following:

The Pottsville Hospital and Warne Clinic

1. The autopsy revealed massive bilateral pulmonary emboli due to deep vein thrombosis (DVT) of the legs found on posterior dissection of the lower extremities.
   The autopsy excluded anatomic causes for DVT such as cancer and other tumors, trauma, cardiovascular disease, congestive heart failure, recent surgery, and obesity. Dr. Fredc concluded that the cause of the DVT was inactivity. I agree with the autopsy findings and opinion.
   I did not examine autopsy photos or microscopic slides of the lung, the veins of the legs, or other organs.

2. There are classical signs and symptoms of DVT that health care providers look for in patients to diagnose DVT and institute diagnostic testing and therapy. However, DVT is frequently asymptomatic or the symptoms are not classical. The first sign of DVT can be pulmonary emboli or sudden death. A high index of suspicion is necessary.

3. It is recommended that all patients be screened for DVT upon admission to a health care facility and then whenever there is a change in their clinical condition.
   Screening can include a check list of risk factors. Each risk factor is assigned a number. The numbers are added and the higher the sum, the more serious or higher the risk for DVT.
   There should be a plan for prophylaxis or treatment for risk categories from moderate to high to highest risk.
   The patient's physician must be notified of the DVT screening score.
   The State of New York Commission on Quality of Care and Advocacy for Persons with Disabilities had recommended a DVT risk assessment process and a plan for prophylaxis or treatment based on the results of the risk factor assessment.

4. Inactivity is a risk factor for DVT including sitting for long periods of travel in an automobile or plane.

OPINION:

Valerie Young died as a result of bilateral massive pulmonary emboli due to deep vein thrombosis of the legs due to inactivity.
Multiple factors contributed to this inactivity including prolonged sitting in a wheelchair, multi drug therapy and drug interactions, and the patient's medical, neurological, and psychiatric conditions.

The Pottsville Hospital and Warne Clinic

Celebrating 110 years
1895 - 2005

It was this inactivity that caused DVT in the legs. The thrombi broke loose in the legs, traveled to the lungs as pulmonary emboli and caused death.

Sincerely,

Richard P. Bindie, M.D., Forensic Pathologist

RPB/cmg

RICHARD P. BINDIE, M.D.
FORENSIC PATHOLOGIST

Pottsville Hospital & Warne Clinic
420 South Jackson Street
Pottsville, PA 17901
(717) 621-5262

Residence
150 Avenue E
Schuylkill Haven, PA 17972
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CURRICULUM VITAE

PREMEDICAL:	LaSalle College, Philadelphia, Pennsylvania, 1959-1962
MEDICAL SCHOOL:	Temple University School of Medicine, Philadelphia, Pennsylvania, 1962-1966
ROTATING INTERNSHIP:	Germantown Hospital and Medical Center, Philadelphia, Pennsylvania, 1966-1967
OBTAINED LICENSE:	Pennsylvania, 1967
PATHOLOGY RESIDENCY:	Anatomical and Clinical Pathology, Germantown Hospital, 1967-1971 (Chief Resident, 1969-1971)
CERTIFIED:	Anatomical Pathology by American Board of Pathology, 1972
CERTIFIED:	Clinical Pathology by American Board of Pathology, 1972
CERTIFIED:	Forensic Pathology by American Board of Pathology, 1992
DIPLOMATE:	American Board of Pathology, Certified in Forensic Pathology
FELLOW:	College of American Pathologists
FELLOW:	American Society of Clinical Pathologists
FELLOW:	American Academy of Forensic Sciences
MEMBER:	National Association of Medical Examiners
MEMBER:	American Medical Association
MEMBER:	Pennsylvania Medical Society
MEMBER:	Past President and Secretary, Schuylkill County Medical Society
MEMBER:	Pennsylvania Association of Clinical Pathologists
MEMBER:	American Society of Microbiology
DIRECTOR:	Department of Pathology, Pottsville Hospital and Warne Clinic, Pottsville, Pennsylvania, 1975-present

RICHARD P. BINDIE, M.D.
Forensic Pathologist

SIXSMITH DECLARATION

EXHIBIT C

New York Hospital Queens

56 Main Street, Flushing, NY 11355 / Tel. [illegible] / Fax [illegible]

Department of Emergency Medicine

May 8, 2008

Jose L. Velez, Esq.
Assistant Attorney General
New York Sate Department of Law
Litigation Bureau—24th Floor
120 Broadway
New York, NY 10271

Re: Estate of Valerie Young by Viola Young, Administratrix, et al, v. State of New York Office of Mental Retardation and Developmental Disabilities, et al

Dear Mr. Velez:

At your request I have reviewed the expert report of Dr. Richard P. Bindie.

Dr. Bindie notes that there are classical signs and symptoms of deep vein thrombosis (DVT) that health care providers look for in patients to make the diagnosis. I certainly agree with that. However, Ms. Young displayed none of the signs and symptoms, which are unilateral leg pain, swelling, or discoloration of the involved extremity.

Nor did Ms. Young have the classical predisposing factors cited in the largest prospective cohort series to date, the Longitudianl Investigation of Thromboembolism Etiology (LITE) which determined the incidence of DVT and pulmonary embolism in 21,680 participants age > 45 years. In that very large study, the incidence was greater in the elderly, men, and patients with cancer, hospitalization, surgery, or major trauma. Ms Young had none of those risk factors.

In another large study, the MEDENOX study, the following factors were found to be statistically significant in causing DVT in acutely ill, immobilized general medical patients: presence of an acute infectious disease, age > 75 years, cancer, or a history of prior venous thromboembolic disease. Ms. Young had none of these risk factors.

The widely accepted Wells score, used by clinicians to determine whether there is sufficient likelihood of DVT to warrant further testing such as venous Doppler ultrasound or CAT scan of the chest, lists the following risk factors: active cancer, paralysis or cast immoblilization of the lower extremity; recently bedridden for more than three days,

localized tenderness along the veins of the leg, entire leg swollen, calf swelling of more than 3 cm when compared to the asymptomatic leg, pitting edema in the symptomatic leg, collateral superficial veins, or an alternative diagnosis as likely or more likely than DVT. Ms Young had none of these risk factors either, and indeed she did have an alternative diagnosis more likely than DVT—dependent edema.

Dr. Bindie suggests that all patients be screened for DVT upon admission to a health care facility or whenever there is a change in their clinical condition. The risk factor check list used to screen patients for DVT includes the following: history of cast or splint immobilization or prolonged bed rest; recent surgery; obesity; prior episodes of venous thromboembolism; lower extremity trauma; malignancy; use of oral contraceptives or hormone replacement therapy; pregnancy or postpartum status; and stroke. Ms. Young had none of the above.

Dr. Bindie suggest that inactivity is a risk factor for DVT, including sitting for long periods of travel in an automobile or plane. While that may be the popular wisdom, it was not borne out as a risk factor in the prospective studies listed above, nor is it borne out by the practical experience of nursing homes and skilled nursing facilities where the majority of the residents are confined to wheelchairs without increased DVT risk. More importantly in this case, while Ms. Young may have spent increasing time in a wheelchair for certain of her mobility needs, she continued to be ambulated and go to physical therapy.

Dr. Bindie's mentions that patients can often have pulmonary embolism or sudden death as their first sign of DVT and thus concludes, "A high index of suspicion is necessary." A high index of suspicion is, of course, always desirable, but a physician needs some signs or symptoms upon which to rest that high index. One could as equally have had a high index of suspicion that Ms. Young would have a heart attack, develop cancer, or be attacked by a fellow resident. For example, cardiac arrest is often the first sign that a patient has coronary artery disease and a stroke is often the first sign that a patient has cerebrovascular disease, two of the commonest causes of death and disability in the United States. That does not mean that we do prophylactic check lists for those conditions in the adult population of the U.S. Rather we evaluate them when they become symptomatic or we do routine annual health examinations, exactly what Ms. Young received in April of 2005.

Finally, Dr. Bindie recommends a plan for prophylaxis or treatment for moderate or high risk patients. It is my opinion based on all of the above that Ms. Young was neither a moderate nor a high risk patient. Nor was she a candidate for DVT prophylaxis. The most effective form of prophylaxis is anticoagulation, typically with a blood "thinner" such as coumadin. Coumadin carries the very real risk of bleeding and is not used when the risk of bleeding outweighs the benefits coumadin might offer. Anticoagulation was clearly contraindicated in Ms. Young because of her fall risk, i.e., should she injure herself in a fall, the resultant trauma with uncontrolled bleeding on anticoagulation would be a greater and more likely risk than the risk of DVT. Ms. Young was also not a candidate for mechanical prophylaxis, which is an intermittent leg compression device

that is used on bed-ridden patients, which Ms. Young was not. The only other prophylactic modality, compression stockings, are useful, if at all, in patients who are confined to bed and would have provided no additional benefit to Ms. Young as she was ambulating and not at bed rest.

In conclusion, I find no merit to Dr. Bindie's opinions, and my own opinions remain as stated in my initial report of February 26, 2008.

Sincerely,

Diane M. Sixsmith, M.D., M.P.H., FACEP